2005 SUPPLEMENT TO MEDICARE PLAN COMPARISON
SUMMARY OF BENEFITS

	Blue Shield HMO	PERS Choice	PERSCare
2005 PREMIUMS			
1 Party	$287.78	$279.60	$289.32
2 Party	$575.56	$559.20	$578.64
Family	$863.34	$838.80	$867.96
CALENDAR YEAR DEDUCTIBLE	None	None	None
LIFETIME MAXIMUM BENEFIT	None	$2,000,000/individual *after Medicare payments*	None
MEDICAL BENEFITS			
Hospital -- Inpatient and Outpatient	No Charge	No Charge*	No Charge*
Physician Visits			
Office	$10 per visit	No Charge*	No Charge*
Home	$10 per visit	No Charge*	No Charge*
Hospital Visits	No Charge	No Charge*	No Charge*
Gynecological Exam	$10 per visit	No Charge*	No Charge*
Allergy Testing/Treatment	$10 per visit	No Charge*	No Charge*
Diagnostic X-Ray/Lab	No Charge	No Charge*	No Charge*
Ambulance	No Charge	No Charge*	No Charge*
Emergency Services	$50 per visit, waived if admitted as inpatient or for observation as outpatient	No Charge*	No Charge*
Home Health Services	No Charge	No Charge*	No Charge*
Durable Medical Equipment	No Charge	No Charge*	No Charge*
Hearing Aid Services	No Charge for exam - $1,000 max for hearing aid every 36 months	20% Co-insurance $1,000 max for hearing aid every 36 months	20% Co-insurance $2,000 max for hearing aid every 24 months

	Blue Shield HMO	PERS Choice	PERSCare
Mental Health			
Inpatient	No Charge	No Charge*	No Charge*
Outpatient - *includes outpatient substance abuse (Medicare pays 50% of the approved amount for most services)*	$10 to $20 per visit	Excess Charges*	Excess Charges*
Skilled Nursing Facility Care			
Up to a 100 days each benefit period in a Medicare approved facility.	No Charge	No Charge*	No Charge*
Enhanced Skilled Nursing Facility Care	Not Covered	Not Covered	20% Co-insurance *(From 101 to 365 days (pre-certified by Blue Cross)*
Speech Therapy	$10 per visit	No Charge*	No Charge*
Physical Therapy	$10 per visit	No Charge*	No Charge*
Occupational Therapy	$10 per visit	No Charge*	No Charge*
Acupuncture	Not Covered	Not Covered	20% Co-insurance
Biofeedback	No Charge	No Charge*	No Charge*
Chiropractic	$10 per visit	No Charge*	No Charge*
Diabetes Services	$10 per visit	No Charge*	No Charge*
Heart Transplants	No Charge	No Charge*	No Charge*
Kidney Dialysis and Transplants	No Charge	No Charge*	No Charge*
Hospice Care	No Charge	No Charge*	No Charge*
Podiatrist Services	Not covered	No Charge*	No Charge*
VISION CARE			
	$10 per exam Limited to one per calendar year	Any amount in excess of the maximum allowance	Any amount in excess of the maximum allowance
		One exam and two lenses per calendar year: one set of frames during a 24-month period	*One exam and two lenses per calendar year: one set of frames during a 24-month period*
		Maximum Allowance: *Exam $35/Frames $30* *Each lens: Single Vision $20; Bifocal $35; Trifocal $45; Lenticular $50; Contact Lenses $100*	Maximum Allowance: *Exam $35/Frames $30* *Each lens: Single Vision $20; Bifocal $35; Trifocal $45; Lenticular $50; Contact Lenses $100*

	Blue Shield HMO	PERS Choice	PERSCare
PRESCRIPTION DRUG BENEFITS			
Retail Pharmacy Program**	30-day supply	Up to a 30-day supply for short-term use	Up to a 34-day supply for short-term use
	$ 5 Generic $15 Formulary Brand $45 Non-Formulary Brand ($30 if medical necessity approved for non-formulary)	$ 5 Generic $15 Formulary Brand $45 Non-Formulary Brand ($30 if medical necessity approved for non-formulary)	$ 5 Generic $15 Formulary Brand $45 Non-Formulary Brand ($30 if medical necessity approved for non-formulary)
Mail Service Program	Up to a 90-day supply	Up to a 90-day supply	Up to a 90-day supply
	$1,000 maximum co-pay per calendar year	$1,000 maximum co-pay per calendar year	$1,000 maximum co-pay per calendar year
	$10 Generic $25 Formulary Brand $75 Non-Formulary Brand ($45 if medical necessity approved for non-formulary)	$10 Generic $25 Formulary Brand $75 Non-Formulary Brand ($45 if medical necessity approved for non-formulary)	$10 Generic $25 Formulary Brand $75 Non-Formulary Brand ($45 if medical necessity approved for non-formulary)

**If benefits are approved by Medicare and you use a provider who accepts Medicare assignment, covered services will be paid in full.*
***Mail order copayment after second fill at retail on maintenance medications applies for PERS Choice and PERSCare.*
Maintenance medication is medication taken longer than 60 days for chronic conditions.

This is only a summary of benefits offered.
Please refer to each plan's Evidence of Coverage booklet for the exact terms and conditions of coverage.